COUNTRY CHIROPRACTIC

CHILDHOOD PATIENT INTAKE INFORMATION

Date: ___/___/___

NAME: **SEX: M | F** **DOB:** **AGE:**

Address: **Postcode:**

Phone (Home): **Phone (Work):** **Mobile:**

Email:

Parent / Guardian Name(s):

Sibling(s):

Emergency contact: (if guardian, write 'as above')

How did you find our clinic? Person: Website Signage Facebook Other:

MAIN CONCERN:

When did it start?

Have they had it before? **Y** **N**

Is it (circle): getting worse constant comes/goes getting better

What caused it / How did it happen?

What makes it better?

What makes it worse?

What treatment have you had? (circle) GP Chiro Physio Other:

GENERAL HEALTH: (please answer to the best of your ability)

Current Health Care Practitioners: (who, and what for?)

List Vitamins/Supplements:

List Current Medications:

List all injuries:

Major Illnesses during lifetime:

Detail any motor vehicle accidents / other injuries:

List surgeries or hospital stays:

List previous x-rays, CT scans, MRI's:

Any Family history of Strokes, Heart attacks, Cancer or other:

Sleeping Posture: (circle) Side / Back / Front

For All ages please indicate below if present or past issues:

- ☐ Clumsiness
- ☐ Hyperactivity
- ☐ Fever
- ☐ Sore throats/Tonsilits
- ☐ Allergies
- ☐ Poor Sleeper
- ☐ Asthma/ respiratory
- ☐ Scoliosis
- ☐ Poor concentration
- ☐ Poor posture
- ☐ Coughs
- ☐ Constipation
- ☐ Skin Rashes/ Issues
- ☐ Meningitis
- ☐ Anxiety/ Depression
- ☐ Colic
- ☐ Bed Wetting
- ☐ Headaches
- ☐ Earaches/ Infections
- ☐ Diarrhoea
- ☐ Leg/ Growing pains
- ☐ Frequent colds
- ☐ Fatigue
- ☐ Unsettled

0- 6 YEARS OLD		
Birth weight:	Birth Length:	Head circumference:
Gestation duration:		
Delivery: (Circle) Vaginal / Caesarean / Suction / Forceps / Breech / Induction / Other:		
Any complications of pregnancy or birth:		
Dominant head turn:		
Feeding: (Circle) Breastfed, Formula, both. Any Issues;		
Is your baby hitting milestones normally: **Y** **N**		
Sitting, crawling, walking issues:		
Other;		

0-18 YEARS OLD
Sports they play or used to play:
Do you wear shoe inserts? (circle) **Y** **N** Details:
Do you wear a dental splint? (circle) **Y** **N** Details:
Other:

MISSED APPOINTMENT & PRIVACY POLICIES

I am aware of the Missed Appointment Policy and associated fees.
I consent to the collection of my personal information as outlined in the Privacy Policy.

Patient/ Guardians Signature: ____ Date: __________________

INFORMED CONSENT TO TREATMENT

Please refer to our informed consent document and appropriate discussions with your practitioner.

Patient / Parent / Guardian Name   Signature   Date

Chiropractor Signature: